Mid Kent and Medway Coroners' Service
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**Telephone:** [redacted]
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Date: 7 October 2024
Case: [redacted]

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

**THIS REPORT IS BEING SENT TO:**

[redacted]

**Secretary of State for Health and Social Care**

## 1. CORONER

I am Ian Brownhill, HM Assistant Coroner for Kent.

## 2. CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

## 3. INVESTIGATION and INQUEST

On 30 November 2022 I commenced an investigation into the death of John Raymond EYRE. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Natural causes

1a Pneumonia

1b Liver Disease

1c

1d

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## 4. CIRCUMSTANCES OF THE DEATH

The deceased was a serving prisoner at HMP Swaleside and had been experiencing a deterioration in his health in the latter part of his life.

It was described at the inquest that there was a sudden deterioration in Mr Eyre's presentation in spring 2022 and mention of a possible lymphoma. It was clear from all of the medical evidence that the clinicians who were treating Mr Eyre thought that lymphoma was the most likely cause of the deterioration in his health. It appears that potential diagnosis was only excluded shortly before his death.

During Mr Eyre's deterioration it is apparent that tests were missed. It is also apparent that he had neutropenic sepsis on more than one occasion. The inquest was not able to come to a conclusion as to what was causing the neutropenic sepsis.

As a result of Mr Eyre's condition, he spent time as an inpatient at Medway Maritime Hospital.

In October 2022, Mr Eyre was due to be discharged from hospital again to return to a custodial setting. The prison healthcare provider was adamant that his needs could not be met in the custodial setting and was concerned that there were outstanding investigations to be completed. A healthcare professional from the prison shared her concerns with staff in the acute hospital. A junior doctor indicated that the concerns would be escalated to a Consultant prior to discharge. That did not happen, instead, there was a telephone conference in which the prison healthcare staff were challenged as to their approach. The responsible Consultant gave evidence at the inquest that she had not been made aware of the concerns of the prison healthcare provider.

Mr Eyre was returned to prison. Shortly thereafter, he was readmitted to hospital by ambulance having been found on the floor.

In hospital, Mr Eyre's health deteriorated and despite efforts at treatment, he died there on 20 November 2022.

The record of inquest states:

*John Eyre was serving a custodial sentence at the time of his death, his health deteriorated in 2022 and he was treated for recurrent sepsis. The root cause of the sepsis was not identified. On 31 October 2022, John was readmitted back to Medway Maritime Hospital as his health had deteriorated. Despite efforts as to ongoing investigations and treatment, John died at Medway Maritime Hospital of pneumonia on 20 November 2022. At the time of John's death he had liver disease which had not been identified.*

The conclusion was a death by natural causes.

## 5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) There was no concrete escalation route when prison healthcare staff challenged the appropriateness and sustainability of discharge from the acute setting.

(2) There was no national guidance document, or national policy in place, which outlined whether a prisoner should be returned to a custodial setting in the absence of the prison healthcare provider's concerns being considered by the patient's consultant.

## 6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you as the Secretary of State for Health and Social Care have the power to take such action.

## 7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 December 2024 . I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

## 8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the Interested Persons in the inquest. I have also sent it to the Prison and Probation Ombudsman who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

7 October 2024

Ian Brownhill

Assistant Coroner for Mid Kent and Medway